Patient-centred care delivered by general practitioners: a qualitative investigation of the experiences and perceptions of patients and providers

Brickley, Bryce; Williams, Lauren T; Morgan, Mark; Ross, Alyson; Trigger, Kellie; Ball, Lauren

Published in:
BMJ Quality and Safety

DOI:
10.1136/bmjqs-2020-011236

1 **Title:** Patient-Centred Care Delivered by General Practitioners: A Qualitative Investigation
2 of the Experiences and Perceptions of Patients and Providers

3 **Article category:** Original Research

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Abstract

Background

Patient-centred care (PCC) is care that is respectful and responsive to the wishes of patients. The body of literature on PCC delivered by general practitioners (GPs) has increased steadily over time. There is an opportunity to advance the work on GP delivered PCC through qualitative research involving both patients and providers.

Aim

To explore the perceptions and experiences of PCC by patient advocates and GPs.

Design and setting

Qualitative description in a social constructivist paradigm. Participants were sampled from six primary care organisations in south east Queensland/northern NSW, Australia.

Method

Purposive sampling was used to recruit English speaking adult participants who were either practising GPs or patient advocates. Focus group sessions explored participants' perceptions and experiences of PCC. Data were analysed thematically using a constant-comparative approach.

Results

Three focus groups with 15 patient advocates and three focus groups with 12 practising GPs were conducted before thematic saturation was obtained. Five themes emerged: 1) understanding of patient centred care is varied and personal, 2) valuing humanistic care, 3) considering the system and collaborating in care, 4) optimising the general practice environment, and 5) needing support for PCC that is embedded into training.

Conclusion

Patient advocates' and GPs' understanding of PCC are diverse, which can hinder strategies to implement and sustain PCC improvements. Future research should explore novel interventions that expose GPs to unique feedback from patients, assess the patient-centeredness of the environment, and promote GP self-reflection on PCC.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Keywords

patient-centred care; person-centred care; general practitioners; primary care; general practice; quality; safety; qualitative description

Introduction

The World Health Organization (WHO) describes patient-centred care (PCC) as care that is respectful and responsive to the wishes of patients (1). A patient-centred approach to health care delivery has been advocated for decades by key health organisations and institutions throughout the world (1-3). General practitioners (GPs) and their international counterparts (i.e. family physicians) are medical generalists who are typically positioned to be the first point of contact for patients entering health systems (1). Health policy suggests that GPs are expected to deliver PCC (3, 4), and studies have reported that patients desire PCC (5-8).

The implementation of PCC has been reported to support higher levels of care quality for primary care systems and organisations and lower costs (1, 9, 10). For patients, PCC has been reported to support adherence to treatment (11), increase satisfaction (12), and improve health outcomes (11, 13, 14). Providers benefit because PCC is associated with enhanced relationships with patients (14), positive perceptions of doctors' performance (15), and higher levels of trust (16). Clearly, the implementation of PCC is a valuable strategy within health care.

Our recent integrative review of qualitative, quantitative, systematic review and mixed-methods articles used evidence to develop a theoretical model of GP-delivered PCC that contained four components: 1) understanding the whole person, 2) finding common ground, 3) experiencing time with patients and 4) aiming for positive outcomes (17). The quantitative studies included in the review tended to explore PCC in elements rather than considering a holistic view (17), indicating the need for more rigorous qualitative research on the topic of GP- delivered PCC (17). Qualitative investigation is valuable because it can effectively capture the context to which PCC is implemented, in conjunction with social experiences and perceptions (18, 19).

Primary care providers and patients have previously demonstrated unique experiences and perspectives of PCC (20, 21). An understanding of both the patient and provider experience of PCC is important to the comprehension of this complex concept (22). Our integrative review showed a clear need for further research on the lived experience of PCC by patients and GPs (17). To our knowledge, no qualitative study of both patients and GPs has been published since our integrative review. Therefore, this study aimed to investigate the perceptions and experiences of patient advocates and GPs regarding PCC.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Patient advocate groups have been consulted with for decades, and have been reported to assist with bridging the gap between research and practice (23). An analysis of data across GP and patient groups has the potential to identify strategies to support greater implementation of PCC by GPs and general practices. Collective findings can ultimately add to the literature on the understanding of GP delivered PCC.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Methods

Methodological overview and research questions

A social constructivist philosophical position was used to ascertain meaning through social interaction (24). The research question was: "How do patients and GPs perceive and experience GP-delivered PCC?" Qualitative description, a form of naturalistic enquiry that allows the investigation of PCC within its context (25), was employed to address this question. Qualitative description is a generic approach that supports the description of a complex concept in everyday language (25), which was significant in addressing the research question. This manuscript adheres to the Consolidated Criteria for Reporting Qualitative Research (26).

Study design

Focus group sessions were held with practising GPs and patient advocate participants in south east Queensland, and northern New South Wales (NSW), Australia. Focus groups were chosen for their ability to explore the lived experience of health consumers and providers, and the social interaction within groups (19). In this study, practising GPs participated in focus group sessions independent from patient advocates, which supported participants to discuss their experiences, beliefs in a safe, peer context. Each focus group session aimed to involve between 4-12 participants to provide a variety of individual perspectives, whilst maintaining order (27).

The primary researcher (BB) is a dietitian and PhD candidate who facilitated focus group sessions under the mentorship of expert qualitative researchers (LB/LW). BB was familiar with PCC research, which had sensitised him to PCC issues. Prior to data collection, BB led the development of a GP-delivered PCC conceptual model (17) and observed GP consultations to gain knowledge of a practical general practice context, language, and process. BB's research lens was patient-focused and influenced by the GP-delivered PCC model. However, the research team implemented group debriefing sessions throughout the research process to enhance dependability and reduce reflexivity biases (19). Focus group questions followed an interview guide that was developed by the research team (Table 1). This guide was informed by the seven stages of an interview investigation (28), tailored for use in a focus group, piloted with four purposely sampled non-advocate patients, and modified before data collection.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Selection and recruitment of study population

Patient advocates and GPs were purposively sampled through three patient advocacy organisations and three general practices in south east Queensland/northern New South Wales. The patient advocacy organisations contained approximately 20, 30, and 80 patient members respectively, whilst the GP clinics contained three, six, and 11 GPs respectively. Eligible patient advocates were English speaking adults who had participated in at least one recent GP consultation (<3 months) and were currently participating in patient engagement activities. Engagement activities described any formal role where one advocates on behalf of other patients in health care. This commonly included being an active member of a patient advocacy group, which are formally organised groups who work towards supporting the well-being of a patient population (29). Advisory groups are made up of individuals with diverse characteristics to best represent their target population (30). Patient advocates are typically trained and experienced in research, and consider the significance for patients throughout the research process (31). They are typically paid by state-based health services and industry for their opinions and to generate information that is understandable and meets the needs of consumers (32). Patient advocates were recruited because of a likely greater ability to speak towards the complexities of PCC and a deeper understanding of the local health system compared with typical patients.

Eligible GP participants were currently practising and English speaking. Three general practice managers and three patient advocacy group chairs were purposely engaged through e-mail to collaborate in the recruitment of participants. Study information sheets were provided to allow recruitment to snowball through managers, participants, and their peers. Practice managers supported researchers by recruiting GPs and scheduling the focus group sessions. No financial incentives were provided to participants. The variety within the patient advocate sample was supported by our sampling strategy and the diverse nature of patient advocacy groups. Written informed consent was obtained from participants.

Focus group interview protocol

Focus group sessions with patient advocates were conducted in the same way as to focus group sessions with GPs. The facilitator commenced the discussion with a short briefing. The facilitator then posed questions to the group in accordance with the structured guide (Table 1). To advance conceptual thinking, the facilitator and/or moderator added probing questions

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

throughout to encourage participants to elaborate on initial ideas. After the first focus group session and initial analysis, theoretical sampling was used where the emerging theory was explored with additional interview questions (33). The GP-delivered PCC model (17) guided theoretical sampling and informed additional probing questions regarding participants' PCC experiences. This was an iterative process, emerging codes and themes were explored in subsequent focus group sessions.

Data collection

Participants' residence postcodes were recorded prior to the commencement of focus group sessions. All other data collection and data analysis were completed simultaneously and the number of focus group sessions and sample size were determined when thematic saturation was reached (34). An iterative sampling approach was undertaken to ensure comprehensive, diverse recruitment (34). Focus group sessions were held in a meeting room known to participants (e.g. workplace) and snack food and beverages were provided. Focus group sessions were audio-recorded using a dictaphone and were subsequently transcribed for analysis. One of the three patient advocate focus groups was moderated by a researcher (KT) who is a patient advocacy group manager. One of the three GP focus groups was moderated by a researcher (MM) who is a practising GP. Moderators used their background and skills to promote a controlled, open dialogue in the group; to add scrutiny to concepts that arose, and to make detailed notes, which assisted with analysis. Participants were provided with a copy of their individual transcript via email and invited to verify its accuracy.

Data analysis

Participants' geographic information was interpreted using scores from the accessibility/remoteness index of Australia (ARIA) (35). Qualitative data were analysed using a constant comparative approach (36) and the six phases of thematic analysis (37). Thematic analysis commenced at the beginning of data collection, where researchers familiarised themselves with the data, completed level one and two coding, and generated initial ideas of thematic concepts to explore in subsequent focus group sessions. Due to this iterative and reflective process, researchers were able to identify the point at which thematic saturation was reached (34). The entire research team took part in level three coding, and reviewed, defined, and named themes (19). The GP-delivered PCC model was not used as a data source, although

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

it influenced data categorisation and interpretation as it shaped the beliefs of the primary researcher. Reflection throughout the analytical process was supported by field notes.

Results

Participants

Twenty-seven participants engaged in focus group sessions between September 2019 and November 2019 and their individual characteristics are displayed in Table 2. More than half the total sample was female (n = 16; 59%) and the mean (SD) age was 55.3 (16.1) years. There were 15 patient advocates (5 males, mean age (SD) 57 (19) years) and 12 practising GPs (6 males, mean age (SD) 53 (12) years). Two patient advocate participants (7%) lived in outer regional areas, which were classified to have significantly restricted access to good services and opportunities for social interaction (35), and the remaining resided in major cities.

Thematic analysis

Five main themes emerged, 1) understanding of PCC is varied and personal, 2) valuing humanistic care, 3) considering the system and collaborating in care, 4) optimising the general practice environment, and 5) needing support for PCC that is embedded into training. Themes one and two relate to participants' perceptions and views on PCC, while themes three to five indicate several barriers and enablers to PCC implementation. The themes are described below, with narrative quotes used to support the data. Patient advocate data is indicated by PA1-15 and GP data by GP1-12.

Understanding of patient-centred care is varied and personal

Perceptions of PCC were highly varied. Perceptions held by patient advocates ranged from a complete lack of knowledge, "I don't even know what that [PCC] is" (PA2), to a detailed and personal understanding, "I think PCC is when my outcome is more important than their process" (PA4). One GP perceived PCC to encompass communication and agreement, "[PCC] is about the patient sharing the GP's thoughts and together coming to an agreement" (GP5). While another GP described their experience of PCC to be listening to patients and responding to their wishes; "[PCC] is identifying what they [patients] want, what their priorities are, and where they're wanting to go" (GP9). Both patient advocates and GPs tended to describe PCC in terms of how they interpreted it personally rather than describing a text-book definition. This individualised interpretation sometimes prevented the practice of PCC as one GP explained:

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

"trying to get people back in for another appointment to do the longer stuff, that doesn't go with their patient-centred ideas, they want it all done now. So that makes it difficult…" (GP2).

Valuing humanistic care

Humanistic care emerged as a theme because it was mentioned by many GPs and patient advocates as a fundamental aspect of PCC implementation. Humanistic care involved GPs making apparent that they care for patients as an individual by avoiding generic care activities and statements; "[my GP] puts a lot of care and attention into managing what I need as a person" (PA1). One patient felt humanistic care to be lacking in the current system; "If we substituted patients for bags of wheat, provided the Medicare number was the same, no one would notice" (PA4). Similarly, one GP expressed that GP prerogative could determine if humanistic care was delivered; "Some [GPs] are more willing to listen to patients on a deeper level than other GPs" (GP3). Patient advocates expressed that being able to discuss things comfortably, feeling listened to and building trust were key experiences of humanistic care:

> Yes, I think it's doctors listening to each individual patient and getting their story. Not just putting them in a box and you're this or you're that… and following the textbook. They [GPs] need to know the full story, the full background of each individual patient to be able to give care that is centred on the patient not on the textbook (PA8).

Humanistic care was valued by GPs because they aimed to form relationships with patients and relate to them as an individual; "I mean lots of people come in with different levels of insights into their health care and we need to relate to them on a whole lot of different levels" (GP3). Although one GP found this difficult to achieve universally, "there has got to be a therapeutic relationship, but I don't think that it is necessarily possible with every patient and doctor" (GP8). Patient advocates wanted GPs to be aware of their own limitations and be transparent about them:

> I think it's important that doctors are quite human, in that they can acknowledge when they don't know everything. They can admit to it. If maybe they don't have all the knowledge about something, they can say 'can I get back to you next time I see you about that' (PA7).

Being transparent about GPs' limitations meant making these explicit through verbal communication, "if their [patient's] expectations are a little bit beyond what you can offer as a GP, well how about a chat with them…" (PA12). Both patient advocates and GPs valued humanistic care and expressed it to be fundamental to PCC.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Considering the system and collaborating in care

Providers reported that they must consider many aspects of the broader health system in the pursuit of PCC. The system factors considered by GPs included costs to patients, the availability and appropriateness of necessary referral services, and ways to support patients to navigate complex pathways within the health system. One GP described a personal experience of considering the cost of investigations (e.g. medical imaging) and reported how this influenced his perception of PCC and how it is achieved:

> I may refuse to do an MRI [magnetic resonance imaging] if they [patients] insist on it, if I don't think it's appropriate. I think cost is important, we are the gatekeepers, so it [PCC] certainly doesn't mean doing what someone wants (GP6).

Providers felt that providing PCC involved timely access to required health services for patients, which sometimes seemed difficult because of "trying to understand the public system" (GP2). One GP stated:

> He [my patient] would prefer to go through the public system, but to get him through the public system… it could be a year's wait before he gets reviewed, and you know if he reckons his tinnitus is that bad he can't work, you've got to get him seen faster than that. So, I have given him the option to at least pay for it and get it started, investigate it further, but these are the sort of decisions we need to make all the time (GP3).

Collaborating with other health professionals, peers, family, and organisations, was suggested by GPs as a strategy to mitigate the complexity of the health system in the pursuit of PCC. One GP stated,

> …our time is limited, it's very important that we can connect them [patients] to helpful resources and allied health professionals. We cannot do everything in one sitting, and we are just one person… allied health, even support from their family is very important (GP12).

Business models with co-located health professionals supported collaboration; "most practices have… the dietitian, physiotherapist… you can directly refer with the care plan… you're confident that they will be seen as soon as possible" (GP12). One patient advocate suggested peer groups could have the potential to support patients to navigate the system, and alleviate pressure on GPs;

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

> It would be great if the health system… had a face [to-face peer] group where a lot of us could go and get support, and someone would have our back and they'd help us navigate through the [system]…because they [GPs] wouldn't know the ins and outs (PA5).

One patient advocate showed compassion towards GPs who struggled to meet the expectations of patients because of the complex system, and recognised the value of collaborating with organisations commissioned to support primary care:

> The mental health system is very opaque, what services exist, how to refer into them et cetera… I've had to find stuff myself because the doctors didn't have that knowledge, and because it wasn't easy to find. So, that de-mystification process needs to happen…we need a mind map, it needs to be more transparent… you can't rely on the doctor to know that, and sometimes it might be new and they haven't had time to find out (PA7).

Optimising the general practice environment

Patient advocates viewed the general practice environment as an important influence on the extent to which PCC is achieved, illustrated by this comment, "person-centred care starts as you walk in the door!" (PA11). Patient advocates noted that environmental design (e.g. purposeful equipment placement, colours, and sounds), general practice culture and reception staff had the potential to promote PCC. One patient advocate who accompanies non-English speaking patients to GP consultations said that PCC can only be implemented if there is a "safe environment no matter your background or age" (PA12). A different patient advocate recounted the experience of a service 'walk through', whereby he provided feedback on the physical environment from a consumer perspective. The participant described how valuable his feedback was to the patient-centredness of the service:

> …someone painted it, changed the seats, changed the whole format. [I] gave them a little bit of [further] advice, and the next time I went it I was like wow! You could feel the [patient-centred] culture from the moment you got there (PA14).

In contrast, the general practice environment was described by GPs as being characterised by funding and time limitations, including "turnstile type medical practices" (GP3); and policy challenges "Medicare is underfunded, without doubt" (GP6) as environmental factors that inhibit the delivery of PCC. General practice reception staff were also regarded as having a role in PCC because they can "help someone feel at ease… communication, respect, and safety start with reception" (PA12). Patient advocates expressed that reception staff are vital in shaping the patient-centred experience; "the first person I meet

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

at the counter… does determine my day at the GP" (PA15). Albeit in a different manner, both patient advocates and GPs expressed that the general practice environment can be optimised to support PCC.

Needing support for PCC that is embedded into training

Patient advocates were concerned about the lack of support for GPs, "…maybe having someone that's there to support our GPs, because I think our GPs don't have any support. Not that I know of." (PA3). Patient advocates suggested that personal and PCC support should be embedded into GP training: "[self-care] should be built into their [training]…" (PA6); "to insist on it [PCC] through more training in medical school, on the need for it, and the importance for it" (PA8);

> How much training is there on PCC when you are a medical student? How much of this is at the front of your training, because by the time you left university… you're really concerned mostly with anatomy and disease…medications, treatments… (PA12).

Patient advocates suggested that a GP self-reflection tool could be valuable to GPs supporting PCC when under pressure; "reflect on why did I start this job? Can I gain this passion back? What makes me connect well with my patients?" (PA3). A different patient advocate said, "and it's that reflection that makes a difference… without that reflection, they are almost stuck in a loop aren't they? It's easier to stick with what they have done…" (PA14). Patient advocates felt that the implementation of PCC could be improved through additional support for GPs that is built into training and ongoing professional development activities.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Discussion

Summary

This study explored the experiences and perspectives of PCC by patient advocates and GPs. The understanding of PCC by GPs and patient advocates was individual and varied, which may impact strategies to enhance PCC. Patient advocates and GPs both valued humanistic care and expressed it to be fundamental to PCC, which may provide ideas to support PCC. Providers in our study reported that system factors, such as treatment costs and scarcity of support services prevented them from being able to use a patient-centred approach. Participants suggested three strategies in supporting PCC, i) considering the system and collaborating in care, ii) optimising the general practice environment and iii) support for GPs that is embedded into training. Our findings have the potential to inform future interventions promoting PCC implementation.

Strengths and limitations

All patient advocate participants volunteered their time for this study, despite usually being paid for their time by their advocacy organisation. The advocacy organisations involved in this study were wholly funded by the Australian National and State Governments. Despite previous claims that patient advocates can be susceptible to biases and conflicts of interests (29), we saw no evidence of this in our study. However, we did not collect detailed information on their demographic characteristics, previous training, or other affiliations.

Qualitative description, the methodological approach utilised, is a key strength because it allowed researchers to remain close to the data throughout the research process, and present findings in a language that closely reflected the language used by participants (25). Participants in the present study discussed PCC in the context of their experience and the local health system. Patients and GPs in the Australian general practice setting may have different experiences than those in other countries. For example, currently, in Australia, patients are able to choose any GP each visit, while many patients in the United Kingdom are enrolled in a single practice (38). The uniqueness of the Australian context may limit the generalisability of data to other health systems. In our focus groups, participants shared their perspectives, which promoted others to decipher and filter their views and opinions. This assisted with the validation of the views and opinions of others. However, an effective focus group dynamic

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

must be achieved to maximise the richness of data collected, (19) and this was limited in two focus groups that contained only two participants in each.

Comparison with existing literature

Patient advocates perceived PCC to be multifaceted and emphasised elements that were important to them. Stewart and colleagues examined if patients perceived their care to be provided in-line with dimensions of PCC from an earlier model (39), and demonstrated that high levels of patient-perceived patient-centeredness predicted positive health outcomes and efficient care (39). Participants suggested that collaborative care could alleviate time demands on GPs and in turn, support PCC. A recent systematic review and qualitative investigation also reported that team-based care initiatives alleviate GP workloads, prevent GP burnout, and support PCC (41). This study underscores the value of collaborative care in support of PCC.

Participants agreed that the general practice environment has the potential to influence PCC. Patient advocates could be a useful future resource for the provision of feedback about the patient-centredness of the physical environment, general practice culture, and reception staff – factors that were not even considered as a part of PCC by the practitioners in this study. Effective health care space design has been reported to reduce stress, anxiety, and increase patient satisfaction (42). In hospitals, environmental characteristics including cleanliness of the space have been reported to influence patient perceptions of patient-centeredness (43). The extent to which GPs and general practices routinely engage with patients to seek their feedback on the general practice environment is unknown.

Implications for research and/or practice

General practices and GPs must be aware that the understanding of PCC among their patient base is individual. The patient is the ultimate judge of PCC, and general practices could support PCC with quality improvement initiatives involving both GPs and patients. There is also the opportunity for GPs to be supported to promote the implementation of PCC. Future research should explore novel interventions that expose GPs to unique feedback from patients, promote GP self-reflection on PCC, and assess the extent to which their environment is patient-centred. Interventions addressing these key issues should be embedded into GP training and ongoing professional development.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Conclusion

This study described the perspectives and experiences of PCC by GPs and patient advocates. Both GPs and patient advocates shared views on PCC concepts, despite individual variations. This study advances the literature on PCC, particularly by presenting novel views of GP-delivered PCC by patient advocates. Our findings can be used to support the development of tools to support patients, general practices, and GPs with PCC.

This article has been accepted for publication in BMJ Quality and Safety, 2020 following peer review, and the Version of Record can be accessed online at https://doi.org/10.1136/bmjqs-2020-011236.

Reference List

1. World Health Organization. People-centred and integrated health services: an overview of the evidence: interim report. World Health Organization; 2015.
2. Australian Commission on Safety and Quality in Health Care. Australian Safety and Quality Framework for Health Care. Canberra; 2010.
3. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs 2011 [Available from: https://www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/understanding/guidelines_pcmh.pdf.
4. The Royal Australian College of General Practitioners (RACGP). Vision for General Practice and a Sustainable Healthcare System: White Paper, February 2019. East Melbourne, Victoria; 2019.
5. Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ. 2001;322(7284):468.
6. Baldwin AS, Cvengros JA, Christensen AJ, Ishani A, Kaboli PJ. Preferences for a patient-centered role orientation: association with patient-information-seeking behavior and clinical markers of health. Annals of Behavioral Medicine. 2008;35(1):80-6.
7. Choi C-J, Hwang S-W, Kim H-N. Changes in the degree of patient expectations for patient-centered care in a primary care setting. Korean Journal Of Family Medicine. 2015;36(2):103-12.
8. Stewart M. Towards a global definition of patient centred care. The patient should be the judge of patient centred care. 2001;322(7284):444-5.
9. Olsson L-E, Hansson E, Ekman I, Karlsson J. A cost-effectiveness study of a patient-centred integrated care pathway. Journal of Advanced Nursing. 2009;65(8):1626-35.
10. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. The Annals of Family Medicine. 2014;12(2):166-71.
11. Saha S, Beach MC. The impact of patient-centered communication on patients' decision making and evaluations of physicians: a randomized study using video vignettes. Patient education and counseling. 2011;84(3):386-92.
12. Bauman AE, Fardy HJ, Harris PG. Getting it right: why bother with patient-centred care? The Medical Journal of Australia. 2003;179(5):253-6.
13. Altin SV, Stock S. The impact of health literacy, patient-centered communication and shared decision-making on patients' satisfaction with care received in German primary care practices. BMC Health Services Research. 2016;16:450-.
14. Kinmonth AL, Woodcock A, Griffin S, Spiegal N, Campbell MJ. Randomised controlled trial of patient centred care of diabetes in general practice: impact on current wellbeing and future disease risk. BMJ. 1998;317(7167):1202-8.
15. Dulewicz V, Van Den Assem B. The GP-patient relationship and patient satisfaction. British Journal of Healthcare Management. 2013;19(12):596-600.
16. Ridd M, Shaw A, Lewis G, Salisbury C. The patient–doctor relationship: a synthesis of the qualitative literature on patients' perspectives. Br J Gen Pract. 2009;59(561):e116-e33.
17. Brickley B, Sladdin I, Williams LT, Morgan M, Ross A, Trigger K, et al. A new model of patient-centred care for general practitioners: results of an integrative review. Family Practice. 2019.
18. McCormack B, Dewing J, McCance T. Developing person-centred care: addressing contextual challenges through practice development. 2011.
19. Liamputtong P. Qualitative research methods, 4th edition. Victoria, Australia: Oxford University Press; 2013.
20. Cocksedge S, Greenfield R, Nugent GK, Chew-Graham C. Holding relationships in primary care: A qualitative exploration of doctors' and patients' perceptions. British Journal of General Practice. 2011;61(589):e484-e91.
21. Sladdin I, Chaboyer W, Ball L. Patients' perceptions and experiences of patient-centred care in dietetic consultations. Journal of Human Nutrition and Dietetics. 2018;31(2):188-96.
22. Wensing M, Vingerhoets E, Grol R. Feedback based on patient evaluations: a tool for quality improvement? Patient education and counseling. 2003;51(2):149-53.
23. Collyar D. How have patient advocates in the United States benefited cancer research? Nature Reviews Cancer. 2005;5.
24. Creswell JW. A concise introduction to mixed methods research: Sage Publications; 2014.
25. Sandelowski M. Whatever happened to qualitative description? Research in nursing & health. 2000;23(4):334-40.

1 26. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-
2 item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007;19(6):349-
3 57.
4 27. Holloway I, Galvin K. Qualitative Research in Nursing and Healthcare. United Kingdom: John Wiley
5 & Sons, Incorporated; 2016.
6 28. Kvale S. Interviews: an introduction to qualitative research interviewing. Thousand Oaks, Calif: Sage
7 Publications; 1996.
8 29. Rose SL. Patient advocacy organizations: institutional conflicts of interest, trust, and trustworthiness.
9 The Journal of Law, Medicine & Ethics. 2013;41(3):680-7.
10 30. McClean J, Trigger K. Not just tea and biscuits; the Gold Coast Primary Health Network process of
11 designing, implementing and operating a Community Advisory Council. Australian journal of primary health.
12 2018;23(6):504-8.
13 31. Ciccarella A, Staley AC, Franco AT. Transforming research: engaging patient advocates at all stages of
14 cancer research. Annals of translational medicine. 2018;6(9):167.
15 32. Sarrami-Foroushani P, Travaglia J, Debono D, Braithwaite J. Key concepts in consumer and
16 community engagement: a scoping meta-review. BMC health services research. 2014;14(1):250.
17 33. Glaser BG, Strauss AL. Theoretical sampling. Sociological methods: Routledge; 2017. p. 105-14.
18 34. Tufford L, Newman P. Bracketing in qualitative research. Qualitative social work. 2012;11(1):80-96.
19 35. Queensland Treasury. Accessibility/Remoteness Index of Australia Brisbane, Queensland2019
20 [Available from: https://www.qgso.qld.gov.au/about-statistics/statistical-standards-classifications/accessibility-
21 remoteness-index-australia.
22 36. Straus A, Corbin J. Basics of qualitative research: Techniques and procedures for developing grounded
23 theory (3rd edition). Thousand Oaks, California: SAGE Publishing, Inc.; 2008.
24 37. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology.
25 2006;3(2):77-101.
26 38. Baird B, Reeve H, Shilpa R, Honeyman M, Nosa-Ehima M, Sahib BO, D. Innovative Models of
27 General Practice. London: The King's Fund; 2018.
28 39. Stewart M, Oates J, Weston WW, Jordan J. The impact of patient-centered care on outcomes. Fam
29 Pract. 2000;49(9):796-804.
30 40. Williams ES, Rondeau KV, Xiao Q, Francescutti LH. Heavy physician workloads: impact on physician
31 attitudes and outcomes. Health Services Management Research. 2007;20(4):261-9.
32 41. Norful AA, de Jacq K, Carlino R, Poghosyan L. Nurse practitioner–physician comanagement: a
33 theoretical model to alleviate primary care strain. The Annals of Family Medicine. 2018;16(3):250-6.
34 42. Schweitzer M, Gilpin L, Frampton S. Healing Spaces: Elements of Environmental Design That Make
35 an Impact on Health. The Journal of Alternative and Complementary Medicine. 2004;10(supplement 1):S-71-S-
36 83.
37 43. Sofaer S, Firminger K. Patient perceptions of the quality of health services. Annu Rev Public Health.
38 2005;26:513-59.

39

Table 1. Focus Group Interview Guide

Research Question	Inquiry Purpose	Main Interview Questions (General Practitioners)	Main Interview Questions (Patient Advocates)	Potential Probing Questions
What are patients' and general practitioners' perceptions and experiences of PCC?	1. Elicit existing views on PCC. 2. Provide an opportunity for open expression of views regarding general practitioner-delivered PCC. 3. Understand the influence of the factors arising from the health system on PCC delivery. 4. Explore perceived ways that the health care system can support the implementation of PCC. 5. Consider participant perceptions regarding the value of monitoring PCC. 6. Identify how patients and clinicians feel that PCC could be effectively monitored by the health system 7. Allow participants time to freely express their thoughts and feelings.	1. Can you tell me what you believe PCC to be? 2. Can you tell me about an experience of PCC? 3. How did the health system influence this experience? 5. Are there any ways in which the health system could support the delivery of PCC? 6. Do you believe that PCC is something the health system should monitor? 8. Is there anything you want to say regarding your experience of PCC that has not come up in this interview?	1. Can you tell me what you believe PCC to be? 2. Can you tell me about an experience with PCC? 3. How did the health system influence this experience? 4. Are there any ways in which the health system could support the delivery of PCC? 5. Do you believe that PCC is something the health system should monitor? 7. Is there anything you want to say regarding your experience on PCC that has not come up thus far?	1. Are there any other aspects of your experience that is important to you? 2. Do you feel as if your peers feel the same way about this as you?

Abbreviations: PCC, patient-centred care

Table 2. Individual Characteristics

Focus Group (*n*)	**Patient Advocate**	Gender (M/F)	Age (y)
1 (moderated by KT)	1	F	22
	2	M	20
	3	F	47
	4	M	68
	5	F	61
	6	F	69
2 (moderated by BB)	7	F	38
	8	F	75
3 (moderated by BB)	9	F	80
	10	M	81
	11	F	44
	12	F	68
	13	F	59
	14	M	64
	15	M	61
Focus Group (*n*)	**General Practitioner**	Gender (M/F)	Age (y)
4 (moderated by BB)	1	F	43
	2	M	70
	3	M	65
5 (Moderated by MM)	4	F	55
	5	F	40
	6	M	67
	7	M	62
	8	M	43
	9	M	39

	10	M	63	1
6 (moderated by BB)	11	F	43	
	12	F	47	